DRAFT
Child and Family Advisory Committee

Meeting Summary
November 15, 2005
Hanover DSS Meeting Room
Ashland

Welcome and Introductions

Jean called the meeting to order and welcomed members. After introductions Jean asked for a motion to accept the minutes from the previous meeting. Catherine moved acceptance of the minutes, Vicki seconded the motion and it passed. Jean asked for any additions to the agenda.

Update on the Values Statement – Dana

Don, Elaine and Dana charged to draft a values statement. (See handout). Elaine, general question related to the values statement. What are we saying about the values statement? The OCFS wants to ensure that the values are incorporated into the work of the Office, writing policies and procedures, seeking funding, etc. to ensure that the OCFS adheres to them. Is it a working document or will the OCFS will commit itself to. We are committed to advancing the system of care; it is an evolutionary process that will change over time. What about going up the chain, will the Department embrace this values statement? Each office has its vision and mission within the context of the Department's vision and mission statement. In the bigger picture, does the Commissioner see this, what is the process for sharing this? In the work of the transformation groups, the group felt very positive about the Commissioner's acceptance of the way we look at children, different from adults, strategic plan was changed to reflect family involvement and family activities. It is important for this committee to agree about the values, to present a united front. Important to talk the same language, looking at what the child needs without regard to the disability. Values statement will help us achieve our goals. Dana will make changes and send final version to the OCFS. Motion to accept the values statement as amended: Vicki moved and Monica seconded acceptance of the values statement. Motion carried.

Agency Presentation – Catherine Hancock - DMAS

- $4 billion in expenditures for 720,000 recipients
- Shared responsibility between the state and the federal government, match rate is 50% for Virginia, can change over time.
- Federal parent agency, Center for Medicare and Medicaid Services (CMS).
- Program requirements, state has to ensure services are provided statewide and comparability of services, equal access and equal availability.
- Freedom of choice of providers.

- Waivers are a way states can get around some of the requirements. Virginia has 7 waivers. Waivers must be approved by CMS.
- Medicaid is insurance for some poor, financial eligibility and categorical eligibility are Medicaid requirements. (See handout). Each group or category will have different eligibility criteria.
- Some eligibility thresholds are set at the federal level and some are at the state's discretion. States may elect to serve eligible groups to serve additional people.
- Description of Medicaid's role with other parts of the healthcare system.
- Description of mandatory and optional eligibility groups and mandatory and optional services covered in Virginia. If a service is outside the mandatory list and medically necessary, it will be covered by Medicaid.
- FAMIS, program for children who do not meet the eligibility requirements of Medicaid. Children in FAMIS are not eligible for EPSDT.
- Virginia has chosen to cover optional services including prescription drugs.
- What about children who have private insurance and Medicaid is secondary insurance; there was brief discussion about situations where this occurs.
- Discussion about day support waivers. This waiver is intended to assist families with consumers on the waiting list for MR waivers.
- Mandatory Medicaid services; state plan services and some optional services are in the state plan. If the state elects for a waiver, those services may be more intense, individuals on waiver are eligible for all other Medicaid services if they are not getting that service under the waiver.
- Link to the Department; MR, MH, TCM, OT, PT, SLP. The Department enrolls individuals for MR, Tech waiver administered by DMAS, will there ever be a waiver for children with mental health needs? There is a rule, Institution for Mental Health Diseases, there is no federal money allowed for "inmates of a public institution or an institution for mental disease". (Language is the language of the rule, which was promulgated thirty or more years ago). Very hard to demonstrate cost savings to the federal government, for example, some states have established managed care waivers.
- Medicaid Reform bill moving through Congress would make it easier to get MH waiver for children in residential treatment. Another provision will allow families to buy into Medicaid.
- MR waiver will cover children with autism until age 6; the MR waiver has served some children.
- Discussion about enrollment levels, Governor's initiative to enroll children in FAMIS has contributed to the increase in enrollment levels and managed care is a growing component of Medicaid in Virginia.
- Although more are being enrolled in managed care, more expenditure is in fee-for-service because of exclusions. Persons who are blind and disabled account for nearly half of all Medicaid spending. The cost of serving the blind and disabled is eight times greater than the cost of care for children.
- Safety net providers rely on Medicaid funding.
- Discussion about how Virginia Medicaid compares with other states.

- Children's Health Program, FAMIS Plus (separate child health insurance program). Certain group of children utilizing Title XXI funds to cover children over age 6 in Medicaid at same income level as those under 6, this program is SCHIP Medicaid Expansion and was created September 2002. Total children covered as of April 1l, 2005: 409,996.
- FAMIS provides comprehensive health care benefits including but not limited to inpatient and outpatient hospital care, physician services, well-baby check ups, prescription drugs, and dental care, vaccinations, vision, hearing and speech language services.
- President's proposed budget: to reduce federal mandatory spending major areas for savings include capped Medicaid administrative costs, restrictions on intergovernmental transfers, reduction in provider taxes limitations on payments to government providers, restrictions and reductions in targeted case management, changes to the definition of rehabilitation services.
- How do individuals access information about Medicaid? Is there somewhere someone can get detailed information. DMAS has a listserv and Catherine encouraged committee to sign up for the listserv. Also the Kaiser Foundation is another valuable resource for information.
- Trainings are available and the Department co-sponsors trainings with DMAS. The Office will monitor training events related to children and will keep committee members informed.
- Do children who are on Medicaid and transition to adult services, is there Medicaid coverage continue. Exception is EPSDT, those services only available until age 21.
- There was a suggestion to consider developing guidance materials for consumers, whose eligible, where do you go, DMAS to develop materials for families, what kinds of services are available, etc. When persons enroll in Medicaid there is a handbook available for recipients, available on the DMAS website. This group can choose to work on a family friendly document. Vicky will bring back the discussion about a family friendly guidance document to VAINFO to see if VAINFO can develop this document.
- DMAS divisions are reviewing all waivers toward the goal of adding consumer-directed components to the waivers, to make services easier to access, more understandable, DMAS underwent a regulatory revision a year ago to increase access to Medicaid services. Looking at what can be tweaked to improve services. The Administration has made it easier for state agencies to work together. CMS must review all changes to the state plan and it has not been easy to get revisions through, DMAS is trying to make changes through policy and policy interpretations and not through regulatory changes.
- VACSB has proposed legislation that will request state funds if federal cuts create untoward consequences for services.
- The Office will develop a list of websites about children's issues and send to committee members

Legislative Issues – 330-F Report – Shirley Ricks

- **Review of the Recommendations**
  - $8.2 million for services for children
  - Report is legislatively mandated
  - Must be submitted each year by June 30th
  - Consistent themes from various children's committees regarding developing system of care, family involvement, etc.
    - Make children's services a priority
    - Family participation at all levels
    - Create an OCFS
    - Establishing services family driven
    - Eliminate silos
    - Promoting evidence based practices
    - System of care principles throughout the development of services
  - All children who need services receive them in a timely manner
  - Significant family involvement
- Sufficient funding, $6.0 million for non-mandated services, adding to the base of funding for children's behavioral health services. The OCFS is seeking interagency participation and family involvement in use of funds. A meeting is planned with OCFS staff in collaboration with VACSB on the use of funds. The Department's guidance about use of funds was that the funds were intended to be flexible and to encourage collaboration at the local level in planning for services for the non-mandated population. Collaboration across agencies at the local level has not occurred statewide.
  - Statistics from a Fact Sheet developed by the 330F committee:
    - One of every five of Virginia's children (approximately 62,000) has a behavioral health disorder that impairs their functioning at home, in schools, and in the community
    - Almost a quarter (23%) of the children and youth in state custody have been placed there by their parents solely to receive necessary behavioral health services (Virginia Mental Health Block Grant, 2005)
    - 24% of the population of Virginia is under the age of 14; 14% of healthcare funds are spent on children; and only 7% mental health expenditures go to children under the age of 18 (Landers, 2001)
    - In FY 2004, more than one out of four of CSA children (27%) received residential services, accounting for 47% of CSA's state pool expenditures. Residential services include group homes, residential treatment facilities, and psychiatric hospital care (OCS, CSA Data Set)
- There were other recommendations not related to funding that included better coordination with other planning groups, make children a high priority, maximize existing funding, develop standards for case

management, use CSA funds flexibly, provide transitional services, establish treatment in secure facilities, etc.

Update on Children's Issues – Shirley Ricks- OCFS

- $1.2 million SA Infrastructure Grant – hiring 4 additional positions in the OCFS. Focus of the new staff will be on substance abuse. Staff will be attending a meeting in Baltimore.
- Pertinent points from the Report of the SEC on The Relinquishment of Custody:
    - Develop the mechanism to coordinate with other affected Secretariats all state level children's services in the Commonwealth. This coordination should include, but not be limited to, the current efforts underway related to the state's Program Improvement Plan (PIP) developed in response to the federal Child and Family Services Review (CFSR) to improve access to mental health services for youth, and the expansion and enhancement of access to child and adolescent mental health services.
    - The Department of Social Services shall collaborate with other child serving agencies to develop, by July 1, 2005, a method for tracking the incidence of custody relinquishment for the sole purpose of obtaining behavioral health treatment services.
    - Review and analyze alternative models of child serving systems that reduce or eliminate categorical funding, decrease fragmentation, and support cost containment strategies.
    - Support development of an appropriate, accessible, and outcomes based continuum of behavioral health and substance abuse treatment services for Virginia youth. Explore differential matches for CSA funding, specifically related to incentives for localities to use CSA non-mandated funds and request necessary policy and code changes that would reduce the local match requirement for localities using their non-mandated CSA allocation.
    - Expand funding for behavioral health services for youth.
    - Explore funding options allowable under the Medicaid and State Children's Health Insurance Programs including those implemented in other states.
- Transition Forum at the Hotel Roanoke March 20 - 22.
- Early Intervention Conference April 25 – 26

Agency Updates

- **DJJ – Scott Reiner**
    - Developing regulations related to mental health transition planning; anticipate draft for public review within the next three months. Legislative mandate for services coming out of detention will have

planning process for transition of youth out of detention. Legislation intended for coordination to ensure access to community based services.
    - DJJ has made budget requests for services for youth in the juvenile justice system.
    - The issue of whose responsible for mental health and behavioral health and where the funding should reside has created some differences of opinion.

- **Commonwealth Center – Don Roe**
    - CC has received funding from Tobacco Settlement, completed study of children with co-occurring disorders, done collaboratively with VTC for Children. Anticipating articles will be published as a result of the study. What's common, what's not with children with co-occurring disorders.
    - Made application for a three year grant to continue services CC is providing.

- **Southwest Virginia Training Center** received a grant for dental services. Regional Health Board will seek funding for dental services for mental health consumers.
- At the next meeting have a parent do a presentation about what services were helpful, what were the barriers, etc. Have a parent story focus on parent recommendations.
- Case Management – have a case manager come and discuss case management, MR and MH and a DD person. Talk about transition process, what it would look like. **Case management from birth to 21**. We can describe case management from a taxonomy protocols however implementation varies from board to board. Suggestion, RBHA to make a presentation about MST and a case manager from Hanover. Next meeting will focus on case management. Definition and taxonomy will be distributed to the committee ahead of time.
- There was interest expressed in having parent organizations do a presentation at a future meeting.
- Request for time for family networking. Family networking will occur from 10:00 until 10:30, meetings will run from 10:30 until 2:00.

The Chair adjourned the meeting adjourned. The motion for adjournment was made by Dana and seconded by Vicky.